

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124B

08454

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County... Worcester
 City or town... Ocean City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Cleveland Adams.4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Evelyn Adams.7. Birth date of deceased (mo., day, yr.) January 12, 1914 6.(c) If alive, give age 30 years8. AGE: Years 32 Months 7 Days 17 If less than one day hrs. min.9. Birthplace Ocean City, Md (Wor C.)
(Town) County, and state)10. Usual occupation Night Club Owner

11. Industry or business

12. Name Marvin C. Adams13. Birthplace Delaware14. Maiden name Sadie Cropper15. Birthplace Maryland16. Informant Mrs. S. C. AdamsAddress Ocean City, Md.17. Burial Burial Date thereof 8/31/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin, Md18. Funeral director Doris A. BurbridgeAddress Berlin, Md19. 8-31-46 19 Selena F. Hayward
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County Worcester
 City or town... Ocean City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 August 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1946 to 29 Aug 1946
 and that I last saw him alive on 29 Aug 1946

Immediate cause of death.....

Acute Dilatation of Heart, 1.5 min.Due to Cirrhosis of Liver 2 yearsAd.Due to Due to Myocarditis Active 2 years

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations No op. Date of op.Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

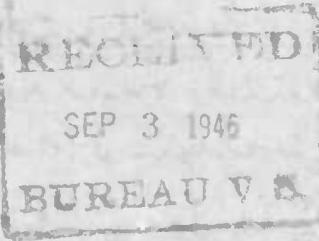
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No op. Date ofWhere did injury occur? No op. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Edmund J. McCay M. D. or otherAddress Ocean City, Md. Date signed 26 Aug 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Md.*

08455

CERTIFICATE OF DEATH

Reg. Dist. No. *350*

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

Francis E. Bishop

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age _____ years

March 30, 1930

8. AGE: Years

Months

Days

If less than one day

16 4 10

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

School boy

11. Industry or business

MOTHER FATHER

12. Name.....

Frank E. Bishop

13. Birthplace

Md.

14. Maiden name.....

Rose Lee Connors

15. Birthplace

Md.

16. Informant.....

Rose Lee Bishop

Address

Rural Pocomoke Twp.

17. Burial

Date thereof Aug 11, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory *Pitts Creek Baptist Cemetery*

Location

Rural Pocomoke Twp.

18. Funeral director.....

Henry E. Watson

Address

Pocomoke City Md.

19. Aug 10 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County *Worcester*

City or town.....

Pocomoke City (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(if rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 8 1946 at *3:47 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

*Fractured skull*Due to..... *Falling off motorcycle*

DURATION

15 min

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *Aug 8 '46*Where did injury occur? *Near Pocomoke City Worcester Md.*

(City or town) (county) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Fall from motorcycle* Injured at work? *No*

23. SIGNATURE

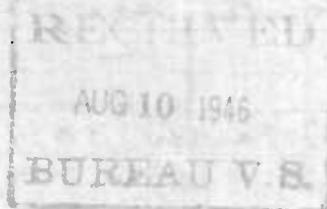
John L. Wiley M.D. Med Exam

M. D. or other

Address

Brown Hts. Jr. Date signed *Aug 8 46*

RECEIVED IN THE LIBRARY OF THE UNITED STATES GOVERNMENT
FEDERAL BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

08456

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, Institution, or street address where death occurred: no
 How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Worcester
 City or town near Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. na
 (If rural, give LOCATION)

2.(a) If veteran, name war: na3. (b) Social Security Number: no

3. (a) FULL NAME: Hester Davis
 4. Sex: Female 5. Color or race: white 6. (a) Single, married, widowed, or divorced: widow
 8. (b) Name of husband or wife: William E. Davis
 7. Birth date of deceased (mo., day, yr.): Decade 6. (c) If alive, give age: no years
 about 1890

8. AGE: About 56 Years — Months — Days — If less than one day: hrs. — min.

9. Birthplace: Berlin Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

MOTHER FATHER 12. Name: Jacquie Davis
 13. Birthplace: Berlin Md.

14. Maiden name: Rachael Davis
 15. Birthplace: Berlin Md.

16. Informant: Mariette Davis
 Address: Berlin Md. RR 2

17. Burial: Burial Date thereof: Sept-3-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Evergreen
 Location: Berlin Md.

18. Funeral director: James P. Stewart
 Address: Salisbury Md.

19. 9-3- Date rec'd by registrar: 15-46 10. Helen F. Hayward
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 19 X 6 midnight M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 19. to 19.

Immediate cause of death: Myocardial degeneration DURATION unknownDue to: of heartDue to: —Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —Date of op.: —Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of Injury: — Injured at work? —23. SIGNATURE: John L. Riley, D.P.M., Esq. M. D. or other: —
 Address: Berwyn Md. Date signed: 8/30/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 912

CERTIFICATE OF DEATH

Reg. Dist. No.

355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County WORCESTER.

City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 YEARS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM BORDEEN DAVIS

4. Sex MALE Color or race 5. (a) Single, married, widowed, or divorced

WHITE MARRIED.

6. (b) Name of husband or wife NORAN DAVIS

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo. day, yr.) NOV. 6, 1880

8. AGE: Years 65 Months 9 Days 3 If less than one day hrs. min.

9. Birthplace BERLIN, MD (TRAPPED)
(Town, county, and state)

10. Usual occupation MERCHANT

11. Industry or business

MOTHER FATHER WILLIAM T. DAVIS

13. Birthplace BERLIN, MD.

14. Maiden name CLARA HAMMOND

15. Birthplace BERLIN, MD.

16. Informant MR RALPH DAVIS

Address BERLIN, MD

17. Burial Date thereof 8/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EVERGREEN

Location BERLIN, MD

18. Funeral director ANNA A. BURPAGE

Address BERLIN, MD.

19. 8-12 Date rec'd by registrar 1946 Helen E. Hayward

(Data rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County WORCESTER

City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)

Street No. TRAPPE
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 9 1946 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1946 to Aug 9 1946 and that I last saw him alive on Aug 9 1946

Immediate cause of death Coronary disease

Due to Generalized arteriosclerosis

DURATION

2da.

20 yrs.

Other conditions
(Include pregnancy within 8 months of death)

Major findings or operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

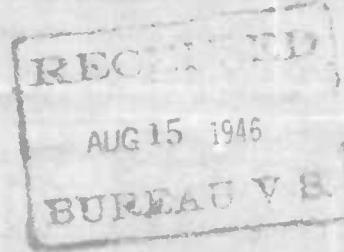
Means of injury Injured at work?

23. SIGNATURE Spacell, M.D.

M. D. or other

Date signed 8/10/46

Address Berlin Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08458

CERTIFICATE OF DEATH

351

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

68 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Olive G. Dukes

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife

David J. Dukes

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

July 19 - 1878

8. AGE:

Years

Months

Days

If less than one day

68 6 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

12. Name

Charles E. Orley

13. Birthplace

Maryland

14. Maiden name

Mary E. Bennett

15. Birthplace

Maryland

16. Informant

My Husband, D. J. Dukes

Address

Midletown, MD

17. Burial

Burial Date thereof Aug. 27/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Midletown, MD

18. Funeral director

Elay O. Dunn

Address

Snow Hill, MD

19. (Date rec'd by registrar)

8/27/46

LeRoy Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Middletree

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

70

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 25 1946 at 12:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18 1946 to Aug. 25 1946

and that I last saw her alive on Aug. 25 1946

Immediate cause of death

Anemia & Cachexia

DURATION

2 mos

Due to Cervixoma of descending Colon with metastases 1 yr

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Cervixoma descending Colon with multiple metastases Date of op. 1-26-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert L. La May, MD

M. D. or other

Address Snow Hill Date signed 7-26-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08459

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County

Worcester
Ocean City

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Nellie Hagen Gough.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married.

B. (b) Name of husband or wife

Engine H. Gough.

6. (c) If alive, give age 92 years

7. Birth date of deceased (mo., day, yr.)

October 25, 1874

8. AGE:

Years

Months

Days

If less than one day

71

9

25

hrs.

min.

9. Birthplace

Newburgh Indiana

(Town, County, and state)

10. Usual occupation

Housewife.

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/24/46
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 8-20

(Date rec'd by registrar)

19. 46 Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Indiana County

City or town Princeton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Aug 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 19 Aug 1946

1946

Immediate cause of death Coronary

Thrombosis of

left coronary artery

Due to Myocardial infarction

Over a period of weeks.

DURATION

Year

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None Date of

Where did injury occur?

None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

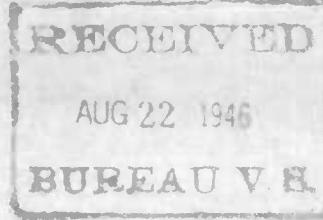
Means of injury

None Injured at work?

23. SIGNATURE

John A. McCay M.D. or other

Address Ocean City MD Date signed 20 Aug 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08460

CERTIFICATE OF DEATH

Reg. Dist. No.

353

1. PLACE OF DEATH:

County

Worcester
Bishop, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laurence E. Hall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 8, 1928

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

17

11

28

hrs.

min.

9. Birthplace

Seabrook, Del.

(Town, county, and state)

10. Usual occupation

Feed store boy

11. Industry or business

Thomas E. Hall

12. Name

Friendship, Md.

13. Birthplace

Father Whaley

14. Maiden name

Berlin, Md.

15. Birthplace

Thomas E. Hall

16. Informant

Bishop, Md.

Address

Burial

Date thereof Aug. 9, 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Shawell Cemetery

Location

near Shawell, Md.

18. Funeral director

Henry S. Watson

Address

Pocomoke City, Md.

19. Date rec'd by registrar

8/8

1946

Mrs. Roy Berger

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Bishop, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-20-4222

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 6 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 25 1946 to Aug. 6 1946
and that I last saw him alive on Aug. 6 1946

Immediate cause of death

Pulmonary Tuberculosis

Due to Pulmonary tuberculosis.

Due to Duration six months cause

Potts Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

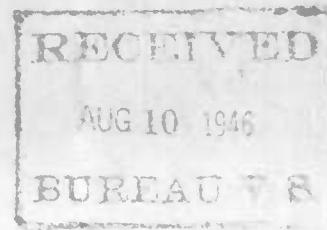
23. SIGNATURE

Chas. R. Law M.D.

M. D. or other

Address Berlin, Md. Date signed 8-7-46

2880



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

08461

Reg. Dist. No. 355

1. PLACE OF DEATH:

County.....

City or town.....

Worcester
Ocean City, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 week
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color of face

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Elzie Maslinski

53

7. Birth date of
deceased (mo., day, yr.)

Nov. 19, 1879

(6.c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

66

8

27

hrs.

min.

9. Birthplace.....

Nyson, Poland (AUSTRIA)

(Town, county, and state)

Hungary

10. Usual occupation.....

Retired machinist

11. Industry or business

FATHER

12. Name.....

Joseph Maslinski

13. Birthplace.....

Austria Hungaria

14. Maiden name.....

unknown

15. Birthplace.....

Austria Hungaria

16. Informant.....

Mr. Stephen

Address

Ambridge, Pa

17. Burial

(Burial, cremation, or removal, which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Woodlawn

Location.....

W. Quippska Pa.

18. Funeral director.....

A. A. B. Burdges

Address

Berlin Md

19. 8-16

(Date rec'd by registrar)

1946 Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Beverly

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 16

1946

et 3. W. P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Myocardial degeneration
of heart

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

John L. Riley D.S. Med Exam
Brownsburg, Md Date signed 8/16/46

RECEIVED

AUG 20 1945

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No.

08462 351

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Nellie E. McEntire

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

John H. McEntire

6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.)

Sept. 13 - 1898

Years Months Days If less than one day

47 11 17 hrs. min.

9. Birthplace

Princess Anne, Somerset, Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

Sister of Drapers

12. Name.....

13. Birthplace

Maryland

14. Maiden name.....

Elizabeth Birmingham

15. Birthplace

Maryland

16. Informant

W. John H. McEntire

Address

Snow Hill, Md

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Location

Snow Hill, Md

18. Funeral director

Elroy C. Thomas

Address

Snow Hill, Md

19. (Date rec'd by registrar)

19. 46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

2.(a) If veteran, name war.....

3. (b) Social Security Number

316-09-6121

MEDICAL CERTIFICATION

2D. DATE OF DEATH

August 30 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 1941 to Aug. 30 1946

and that I last saw her alive on Aug. 30 1946

Immediate cause of death

Chronic Degenerative

Myocarditis

Due to Rheumatic Fever or

Arthritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

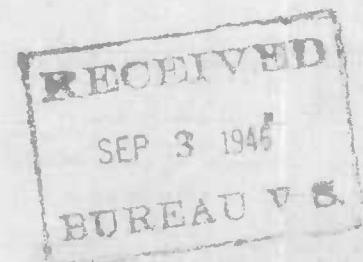
23. SIGNATURE

M. D. or other

Address

Date signed

Signature



PLEASE WRITE PLAINLY, WITH ~~BLANDING~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

08463

354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

New Stanton

City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Ralph Nichols

4. Sex

Male white

5. Color or race

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 25-1946

6. (c) If alive, give age — years

8. AGE: Years

Months

Days

If less than one day

4 23

hrs.

min.

9. Birthplace: Wilmington, Newcastle Del

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Harry F. Nichols

Virginia

MOTHER

13. Birthplace: Juanita Boston

Maryland

14. Maiden name

15. Birthplace: Mrs. Juanita Nichols

Rural Stockton Md.

16. Informant

Address: Aug 20 1946

17. Burial

(Burial, cremation, or removal) Cemetery Date thereof

Cemetery or Crematory: Presbyterian Cemetery Date (month) (day) (year)

Location

Pocatello City, Idaho

18. Funeral director

Address: Glancy & Elzation

Pocatello City, Idaho

19. Date reg'd by registrar

19th May M. Taylor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Rural Stockton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18

1946 at 4:01 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on

Immediate cause of death: Convulsions due to epilepsia. DURATION Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE

M. D. or other

Address: Brown Field Esq. Date Signed: 8/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 853

08464
853

1. PLACE OF DEATH:
 County Worcester
 City or town Bushyville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Bushyville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. No number
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war:

3. (a) FULL NAME *William B Morris Sr.*

3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Eva L. Morris

7. Birth date of deceased (mo., day, yr.) Jan 22 1869

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace Delaware

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business " "

MOTHER FATHER 12. Name Armwell Morris

13. Birthplace Del.

14. Maiden name Charlotte Brascuer

15. Birthplace Del.

16. Informant W. B. Morris Jr.

Address Bushyville, Md.

17. Burial Date thereof Aug 22 46
 (Burial, cremation, or removal. Which?) J.O.T. (month) (day) (year)

Cemetery or crematory:

Location Bushyville, Md.

18. Funeral director M. Fisher Watson

Address Selbyville, Del.

19. Date rec'd by registrar Aug 22 46
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 22 1946 and died 1946

and that I last saw him alive on Aug 16 1946

Immediate cause of death Cerebral Hemorrhage

DURATION 8 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

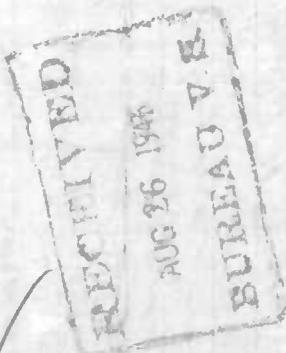
Injured at work?

23. SIGNATURE *Joe Jacobs*

M. D. or other *Delbyville, Del.*

Date signed Aug 17 46

J. R. Galle
J. P. Muller
J. P. Muller



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

08465

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P.D. #1

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Home up J

11. Industry or business

at home

12. Name.....

Carl Schultze

13. Birthplace.....

Germany

14. Maiden name.....

no record

15. Birthplace.....

Germany

16. Informant.....

Burt Ernest Neuman

Address

P.D. #1, Salisbury, Md.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof Aug 12 1946

Cemetery or crematory.....

Smullen Cem

Location

Wm. H. Luke Worcester Co. Md.

18. Funeral director

Hollingsay & Co. Walter P. Hollingsay

Address

Salisbury Maryland

19. (Date rec'd by registrar)

8/12/46 Robert Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Aug. 9th 1946 at 130P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 9th 1946 to Aug 9, 1946

and that I last saw h... alive on Aug 9, 1946

Immediate cause of death.....

drowned

Due to.....

Chronic Glomerulonephritis

?

DURATION

1 week

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

John H. Yaman M. D. or other

Address 238 Lamont Ave Date signed Aug 11, 1946

Salisbury

SEARCHED

AUG 15 1944

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 355

18466

1. PLACE OF DEATH:
County..... Worcester

City or town..... Ocean City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Six (6) Months

Hospital, Institution, or street address where death occurred:

..... 9 North Baltimore Ave.

How long in hospital or institution?

3. (a) FULL NAME

Edrei Uriah Sauble

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife..... Ruth N.

7. Birth date of deceased (mo., day, yr.) August 21, 1881

8. AGE:	Years	Months	Days	If less than one day
	64	11	14	2 hrs. min.

9. Birthplace..... Beckleysville
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Carpenter

12. Name	Eli S. Sauble
13. Birthplace	Maryland

MOTHER FATHER	Sarah Jane Shaver
---------------	-------------------

14. Maiden name	
15. Birthplace	Maryland

16. Informant..... Ruth N. Sauble

Address 9 North Balto. Ave., Ocean City, Md.

17. Burial Date thereof..... Aug. 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Meadowridge

Location Baltimore, Maryland

18. Funeral director..... Hill & Johnson

Address Salisbury, Maryland

19. 8/4/46 Helen S. Hayward
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore, 7
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 5314 Wayne Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 August 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 July 1946 to 4 August 1946
and that I last saw him alive on 1 August 1946.

Immediate cause of death Coronary Thrombosis Acute.

Due to Hypertrophy of heart.

Due to:

Other conditions None.

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op.

Autopsy results No aut.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None. Date of

Where did injury occur? (City or town) (County) (State)

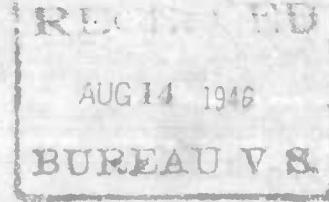
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Glenn P. McCoy M. D. or other

Address Ocean City, Maryland Date signed 8/4/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 351

0846351

1. PLACE OF DEATH:

County..... MarylandCity or town..... Newark, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 25 yearsHospital, institution, or street address where death occurred: NoHow long in hospital or institution? No

3. (a) FULL NAME

Minnie E. Spence

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female a.a. Married6. (b) Name of husband or wife Hariel Spence7. Birth date of deceased (mo., day, yr.) Aug 7 about 19038. AGE: Years about 43 Months - Days - If less than one day .hrs. .min.9. Birthplace Berlin, md

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Same as above12. Name George Morris13. Birthplace Berlin, md14. Maiden name Emma Tingle15. Birthplace Berlin, md16. Informant Hariel SpenceAddress Newark, md17. Burial Burial Date thereof Sept. 1-1946
(Burial, cremation, or removal. Which?)Cemetery or crematory TyreLocation Berlin, md18. Funeral director Jane of StewartAddress Salisbury, md19. Date rec'd by registrar 9/1 1946 Relay Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MarylandCity or town Newark, md (If outside city or town limits, write RURAL and give nearest town)Street No. No (If rural, give LOCATION)2.(a) If veteran, name war No3. (b) Social Security Number No

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 2 1946 to Aug 30 1946 and that I last saw her alive on Aug 30 1946.

Immediate cause of death

Respiratory Paralysis.Due to Muscular Constrictor
Muscular accident.Due to Malignant Hypertension. 1 year.

Other conditions

DURATION

2 hr

4 hr

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert La Mar, M.D.

M. D. or other

Address Baltimore, Md. Date signed 130/46

RECEIVED

SEP 3 1946

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

08469

350

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

58 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Hester Jane Sturgis

3. (b) Social Security Number

4. Sex

Female Colored Married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Wesley Sturgis

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 24, 1875

8. AGE:

Years Months Days If less than one day
70 7 2X hrs. min.

9. Birthplace

Somerset County, Maryland

(Town, county, and state)

10. Usual occupation

Domestic

Private home

11. Industry or business

Joseph Pittman

12. Name

Baltimore, Md

13. Birthplace

Eliza Becket

14. Maiden name

Mrs. Thos. Applegate

15. Birthplace

6th Street, Pocomoke City, Md

16. Informant

Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Young Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18, 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31, 1946, to Aug 8th, 1946,

and that I last saw her alive on Aug 8th, 1946.

Immediate cause of death

Coronary Occlusion Sudden death

Due to Coronary insufficiency SK.

Due to

Coronary insufficiency SK.

Other conditions Deposition

Some years

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

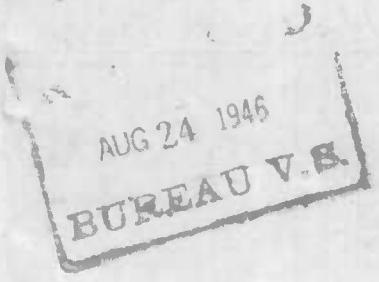
Means of Injury Injured at work?

23. SIGNATURE

N. E. Partwin M.D. or other

Pocomoke City, Md Date signed 8/21/46

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WORCESTERCity or town BERLIN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Edward Townsend

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married.

6. (b) Name of husband or wife

Hettie L. Townsend

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

August 23, 1867.

8. AGE:

Years

Months

Days

It less than one day

78

11

26

hrs. min.

9. Birthplace

Newark, Del. Md.

(Town, county, and state)

10. Usual occupation

Timber dealer.

11. Industry or business

Jessiah Townsend

12. Name

Mary Vandome

13. Birthplace

Md.

14. Maiden name

15. BirthplaceMary Vandome

16. Informant

Mrs. W. E. Townsend

Address

Berlin, Md.

17. Burial

Date thereof 8/21/46
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Berlin, Md.

18. Funeral director

Dame D. Burbage

Address

Berlin, Md.

19. 8-20

Date rec'd by registrar

19. 46 Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WORCESTERCity or town BERLIN (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Aug 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Aug 1946 to 19 Aug 1946and that I last saw him alive on 19 Aug 1946Immediate cause of death Cerebral cardiachemorrhage.

DURATION

4 days

Due to Hypertensive Cardi Ossaceous disease.

10 years

Due to.

Other conditions.

(Include pregnancy within 8 months of death)

Major findings of operations None.

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None. Date ofWhere did injury occur? None. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) None.Means of injury Injured at work?23. SIGNATURE Elvyn P. McCoy M. D. or otherAddress Reed City Md. Date signed Sept 25 46

RECEIVED

AUG 22 1945

BUREAU V.S.